COMMONWEALTH OF AUSTRALIA

Copyright Regulations 1969

Warning

Ritter, A. & Lintzeris, N. (2004). Specialist interventions in treating clients with alcohol and drug problems. In Hamilton, M., King, T. & Ritter, A. (Eds.), *Drug use in Australia: preventing harm*. Melbourne: Oxford University Press.

Pages copied: 221–235

16

Specialist Interventions in Treating Clients with Alcohol and Drug Problems

Alison Ritter and Nick Lintzeris

Joe's story

Joe, a 34-year-old single guy, is not travelling too well. For the past few months he has been drinking every other day, to the point of blackout. He is also using 'speed' on weekends at parties and sometimes dabbles with heroin. This started when his girlfriend left him at the same time that he lost a big contract at work. Joe has had some problems with drug use in the past. During his teenage years he experimented quite extensively. In his early twenties, at university, he developed a dependence on heroin that lasted about 6 months—until he realised that he would not be able to graduate unless he stopped using 'smack'. He went cold turkey, stayed with a friend for a week, didn't eat, had cramps and diarrhoea, and was pretty uncomfortable. Since then Joe's alcohol and drug use has not created problems for him—until now. He has tried, by himself, to cut down on his drug use, but feels depressed about his life, his girlfriend, and his work problems, such that he can really only go one day without using some kind of drug. He knows that he will need some kind of professional help this time around. What are his choices?

A comprehensive approach to reducing drug-related harm to individuals, communities, and society requires multifaceted interventions. These interventions can be concerned with supply reduction (reducing availability), demand reduction (reducing the demand, by potential or actual drug users,

for drugs) and, lastly, by modifying the environment so as to improve safety. These three arenas of intervention—supply reduction, demand reduction, and environmental modification—have come to be regarded as the cornerstones of any comprehensive and effective response to alcohol- and drug-related harm.

This chapter is concerned with the reduction of demand. The goal of demand reduction strategies is to reduce the harms associated with the misuse of drugs by increasing the likelihood that individuals adversely affected by drug misuse will lessen their demand for the particular drug, or drugs. This may be achieved via abstinence from drugs or by controlling use. Treatment is the primary demand reduction strategy, and we describe the following different types of specialist treatment:

- self-help
- controlled-use interventions
- brief interventions and motivational interviewing
- withdrawal treatment
- individual and group counselling
- outreach
- peer support
- psychotherapy.

(Pharmacotherapy maintenance treatments are discussed in chapter 17.)

In Australia, treatment is provided largely through public, government-funded services. The majority of services are free of charge or involve nominal costs to the client. Treatment practitioners in the specialist alcohol and drug field include psychologists, nurses, social workers, doctors, occupational therapists, and welfare workers. The use of multidisciplinary teams enables attention to be paid to the variety of factors influencing the treatment of addiction, including the physiological, psychological, and social domains. Descriptions of these treatments in the British context can be found in a review of English drug treatment services (Department of Health 1996) and, in the United States context, in a publication produced by the American Institute of Medicine in 1990 (Institute of Medicine 1990).

It is worth noting here that many people who experience problems with alcohol and drugs change their behaviour; that is, they 'recover' without the use of health services. Indeed, this may describe the recovery of most people with problems (Cunningham 1999). This has been a growing area of investigation. Formal treatment is defined as any treatment delivered by a professional. Recent research has explored the ways in which people have recovered without the use of formal treatments, and how they may differ from those who recover with the aid of treatment (Blomqvist 2002). Those who recover without recourse to formal treatment appear to have a different recovery pathway—it is a more gradual process and usually is triggered by positive key events, whereas the recovery for treatment seekers is prompted by escalating use and problems. Interestingly, there is no evidence that those

who recover by themselves differ demographically or in terms of duration and severity of drug use from those who recover with treatment, with the exception of heroin use (which has a higher usage rate in the treated population; Blomqvist 2002).

Self-help programs

Self-help programs are widespread all over the world. Typically, they provide informal, unfunded, anonymous access to assistance. Alcoholics Anonymous (AA) commenced in the United States in 1935 with a meeting between Bill W. and Dr Bob, two alcohol-dependent individuals attempting to achieve abstinence. The network of self-help fellowships (Narcotics Anonymous, NaAnon, Families Anonymous, Gamblers Anonymous, and so on) stem from AA and the primary philosophy of that movement. A 12-step program guides the recovery process. These steps include participants acknowledging that their recovery resides in admitting powerlessness over the substance, acknowledging the existence of a higher power, self-scrutiny and reparation, and contribution to the self-help fellowship. Meetings are held in public venues 7 days a week, and members are able to attend as many meetings as they wish. Self-help programs focus on the goal of abstinence. The majority of time in meetings is taken up with members speaking of their experiences as drug users and of the current life issues they face.

Participants in self-help programs report deriving significant strength from the interpersonal nature of the programs, the regularity and routines observed in meetings, and the opportunities that the program provides to assist others or work in voluntary service roles in the fellowship (Makela 1996). All self-help programs are anonymous, and members are prohibited from revealing, to the media and to the public, the fact that they are participants. In the United States, self-help philosophy provides the framework for many residential services and programs. In contrast, the self-help fellowship in Australia is largely divorced from the provision of treatment by health professionals.

Research into the effectiveness of self-help groups largely has been limited to longitudinal, non-randomised studies. The small amount of research to date suggests that regular weekly participation in AA is effective in maintaining abstinence. Participation in self-help as an adjunct to other treatments enhances treatment outcomes, and it appears that self-help is as effective as other treatment modalities (Fiorentine 1999; Florentine & Hillhouse 2000). However, like all treatments, self-help has a high drop-out rate in the early months of treatment, and hence some studies may be biased towards more positive results because they include only those who have persisted with self-help. The advantages of self-help are its easy accessibility and the high levels of social peer support that it provides. Both factors are considered important facets of successful treatment in general.

Controlled-use interventions

Controlled use refers to the establishment of control over any one or more of the following:

- the using situation
- the frequency of using
- the amount of substance used at any one time.

Controlled use is readily distinguishable from spontaneous social use. In contrast to spontaneous social use, controlled use involves the user setting limits to dose and frequency, and setting conditions on the type of using situation. Users may also control their drug use by making a decision not to take drugs while they are in particular moods—for example, when they are depressed or anxious. Professionals pursuing controlled-use interventions as a treatment option for their clients have a variety of specific procedures at their disposal, depending on the outcome of their investigation into what the most important precipitants of relapse are for the particular client (Pead 1984). Controlled-use interventions can be implemented in a range of settings. Clients can be seen on their own, with their spouse (or other family member/s) or in groups, and as inpatients or outpatients.

The concept of 'controlled drinking' has long been the subject of (frequently heated) debate. This debate stems from disagreement over the cause, or causes, of substance dependence. On the one hand are those who believe that 'alcoholism' is a genetically acquired disease that cannot be cured but can only be held in check by total abstinence. For proponents of this view, controlled drinking or controlled drug use is unachievable, and the view that it is achievable is believed to be a dangerous view to promote. On the other hand are those who believe that dependence is a learned behaviour that can be rectified by learning new methods of coping with life experiences. From this latter perspective, controlled use becomes a viable and important treatment option. Somewhere in between lie those who, intellectually, believe the latter explanation but, experientially, have found that control is rarely regained by previously dependent substance users. The most important factor in controlled use appears to be the client's own goal. If a client desires to be completely abstinent, then controlled-use interventions are clearly inappropriate. Likewise, a client who wishes to continue drinking—for example, in a moderate fashion—will find abstinence-based programs unattractive.

The effectiveness of controlled-drinking interventions has now been assessed by many studies. However, as yet, the population samples used in these studies have all comprised men. Heather and Robertson (1981) have provided a comprehensive review of the research in this area. They report that a number of studies in the controlled-drinking literature show that good outcomes are associated with certain client characteristics, including

an intact and fairly caring marital relationship, continued employment, social stability, a comparatively short duration of problem drinking, and low severity of drinking symptoms. Heather and Robertson argue that controlled-use interventions for clients with such characteristics are more likely to succeed than controlled-use interventions for clients who are divorced or separated, unemployed, possibly homeless, and who have a long history of being physically dependent on alcohol (Heather & Robertson 1981).

Clinical treatment guidelines outlining the procedures for implementing a controlled-use intervention are available (Addy & Ritter 2000a). There have been very few structured programs involving health professionals advising clients on controlled use of heroin or amphetamines, and even fewer research initiatives relating to them. This is mainly because the illicit nature of these substances has made treatment personnel reticent about aiding controlled use, thereby reducing the development and availability of such programs. However, controlled-use programs in relation to cannabis are now becoming more common in Australia. It is likely that, as the treatment field becomes more aware of the need to match client goals with treatments, there will be considerable expansion of controlled-use interventions. Controlled-use interventions have generally been targeted at individuals who do not display a dependence syndrome. A dependence syndrome is characterised by frequent regular use (usually daily), increased physical tolerance to the drug, withdrawal symptoms on cessation of drug use, and impairment in psychosocial functioning. Individuals who are dependent on drugs usually have been treated in abstinence-based programs. Over the past 5 years or so, however, there has been increasing acknowledgment of the diversity of client goals and increasing awareness of the changes that may take place in the nature of a client's treatment over the course of time. Thus, controlled-use interventions, which currently concentrate on those who do not present with a dependence syndrome, may be broadened to encompass those who have attempted abstinence-based programs in the past (and have not succeeded) or those chronically relapsing substance users who could use controlled-use strategies to limit the length or extent of a relapse.

Brief interventions and motivational interviewing

As the name indicates, brief interventions are delivered in a short time frame, ranging anywhere from 10 minutes to four hour-long sessions. They are generally directed at people with lower levels of dependence. Brief interventions usually consist of five components:

- providing feedback about the level of alcohol or drug use and the harms
- recommending a change in behaviour with clear and firm advice to cut down on use

- presenting options to facilitate the change
- checking and responding to the client's reaction
- providing follow-up care.

There is an extensive literature in the alcohol field regarding the effectiveness of brief interventions, particularly in primary care settings (Bien et al. 1993; Wilk et al. 1997; Fleming & Manwell 1999; Finney et al. 2002). Brief interventions, usually lasting for under three sessions, demonstrate behavioural change over and above no interventions; that is, compared to nothing. In some instances brief interventions can be as effective as more intensive interventions. However, it should be borne in mind that the greatest effects come from those brief interventions that are conducted opportunistically. That is, those provided to people who are not seeking treatment for an alcohol or drug problem, such as in the emergency department of a hospital or when attending a general practitioner for a regular check-up. The evidence for the effectiveness of brief interventions for those people explicitly seeking treatment is less strong than for those provided opportunistically.

There is a growing literature in relation to brief interventions for cannabis users. A number of studies have found one- or two-session interventions with cannabis users to be superior to wait-list controls (Stephens et al.1994; Stephens et al. 2000; Copeland et al. 2001). In an Australian study that did not have a control group, a single-session cannabis intervention was demonstrated to significantly reduce cannabis use, with maintenance of change at 3 months (Brooke et al. 1998; Lang et al. 2000). Research on brief interventions for illicit drug use other than cannabis is largely lacking.

Motivational interviewing is a therapeutic approach to help clients build motivation and reach a decision to change (Addy & Ritter 2000b). The approach aims to facilitate expression, clarification, and resolution of ambivalence that may block a client from making a commitment to change. In the early 1980s, Miller (1983, 1985) presented a model of motivation described as a 'state of readiness' or 'eagerness to change'. Motivation is seen as a dynamic, changing characteristic. It can be influenced by external factors including specific therapist behaviours; that is, therapists can change someone's motivational state thereby enabling them to make changes to their drug use behaviour. The critical conditions for precipitating change may be contained in a relatively brief interaction.

Mattick and Jarvis (1993) report that motivational interviewing is an appropriate intervention for problem users 'who are not yet ready to change' or 'who are experiencing ambivalence (or conflict)' about their substance using/abusing behaviour (Mattick & Jarvis 1993, p. 189). When a client presents as 'highly motivated to change', motivational interviewing 'may be useful in reinforcing the client's motivation to change by exploring what the client hopes to achieve by changing' (Mattick & Jarvis 1993, p. 189). Miller and Rollnick (1991) suggest that motivational interviewing is

particularly helpful with clients who are uncertain or ambivalent about the need to make changes to their behaviour. At the same time, there is little research evidence on whether any clients do not benefit from motivational interviewing. It is generally regarded as a cornerstone intervention, applicable to all client groups.

A number of clinical trials have evaluated motivational interviewing, and there have been published meta-analytic reviews (Noonan & Moyers 1997; Dunn et al. 2001). The research has supported the efficacy of motivational interviewing. It is important to note that the strongest evidence in support of motivational interviewing comes from its use as an enhancement to more intensive alcohol and drug treatments (Dunn et al. 2001), rather than as a single, stand-alone intervention. Furthermore, and unsurprisingly, motivational interviewing is likely to be less effective than more intensive interventions (Project MATCH Research Group 1997).

Withdrawal interventions

Drug withdrawal refers to the development of a substance-specific syndrome arising from the cessation of (or reduction in) heavy or prolonged substance use. This syndrome causes significant distress, and often impairs social and occupational functioning, and other important areas of life (American Psychiatric Association 1994). The features, severity, and duration of drug withdrawal depend on:

- the drugs used by the individual
- the frequency, quantity, and duration of use
- the individual's knowledge and understanding of what to expect and how to cope
- the individual's physical, psychological, and psychiatric condition
- the environment around the individual, including social supports or stressors.

While a withdrawal syndrome is very rarely fatal (with the exception of untreated alcohol withdrawal), many drug users nevertheless experience considerable distress during withdrawal, and severe complications such as seizures, psychosis, aggression, or suicidal behaviour are not uncommon. Generally, the severity of symptoms during alcohol, heroin, or nicotine withdrawal peaks after 4 to 7 days. Withdrawal syndromes for other drugs are more prolonged (weeks to months for withdrawal from benzodiazepines or methadone).

While many individuals undergo withdrawal without approaching withdrawal services (Gossop et al. 1991), others utilise a range of health services to assist them during withdrawal episodes. The primary goal of withdrawal interventions is to assist individuals to complete withdrawal safely and comfortably (Frank & Pead 1995; Mattick & Hall 1996). Generally,

withdrawal services offer the following:

- assessments of drug use, general health, and social circumstances
- provision of information
- supportive care such as counselling
- regular monitoring of symptoms and general progress
- pharmacotherapy to prevent or relieve severe symptoms
- initiatives linking the client to relevant health and welfare services.

Sometimes, withdrawal is characterised as either 'medicated' or 'unmedicated'. Unmedicated withdrawal, or 'cold turkey', relies upon the provision of a supportive, calm environment that can help to ease withdrawal symptoms. Most funded withdrawal treatments do provide symptomatic medications to reduce or prevent the withdrawal symptoms. There have been recent advances in the evidence base for effective medications to use in withdrawal. In relation to alcohol withdrawal, the most commonly used medications are benzodiazepines, for which there is good research evidence (Mayo-Smith 1997). Cannabis withdrawal treatment involves supportive counselling along with provision of information plus a structured plan of cannabis reduction and cessation. Pharmacological interventions are not regarded as routinely warranted for cannabis withdrawal (Gowing et al. 2001). There are no specific medications for psychostimulant withdrawal, but the basic approaches to drug withdrawal are still used: supportive counselling, a safe environment, information provision, and symptomatic relief. There is a good body of research evidence related to heroin withdrawal. Interventions can be categorised as gradual reducing doses of prescribed opiates (such as methadone or buprenorphine); symptomatic medications (including alpha-adrenergics like clonidine); or the use of opiate antagonists to precipitate and hasten the withdrawal episode (naltrexone). In Australia, the most common approach historically has been symptomatic treatment, with growing interest in the use of buprenorphine. Research evidence indicates that methadone is more effective as a heroin withdrawal treatment than clonidine (largely due to superior retention in treatment; Gowing et al. 2001). Buprenorphine has been compared with symptomatic withdrawal (including clonidine) in both outpatient and inpatient studies, and demonstrates superior outcomes on a number of withdrawal measures and, importantly, on post-withdrawal treatment retention (O'Connor et al. 1997; Gowing et al. 2001; Lintzeris 2001).

In the late 1990s, Australia saw significant public interest in the 'miracle cure' of naltrexone. However, the research on the efficacy of naltrexone for heroin withdrawal is limited. A number of studies have reported successful withdrawal from opiates within 2 to 5 days using clonidine plus naltrexone (Charney et al. 1986; Kleber et al. 1987; Brewer et al. 1988; Vining et al. 1988; Senft 1991). However, there have been only two randomised trials (Gerra et al. 1995; O'Connor et al. 1997). Both reported positive findings for the withdrawal technique, but O'Connor et al. (1997)

found buprenorphine to be superior on some measures. A variant of the technique includes the use of anaesthesia or sedation. The duration of the withdrawal episode is reported to be 24 hours (however, most experienced practitioners and researchers note a persistent discomfort for 2 to 3 days), with the acute stage lasting 2 hours (Loimer et al. 1993). There have been very few published research reports on anaesthetic/sedation withdrawal using naltrexone, and the technique remains somewhat controversial (see for example, Simon 1997; Gossop & Strang 2000).

Acupuncture has been used successfully for some clients, although this is not an established approach. Psychotherapy or intensive counselling interventions have little role in the management of withdrawal. Withdrawal services can be provided in inpatient, outpatient, or home-based settings.

Withdrawal should not be considered a stand-alone intervention that results in enduring abstinence (Hulse et al. 2002). Indeed, research indicates that undergoing a stand-alone withdrawal episode has little long-term effect on drug use. Withdrawal interventions are short-term interventions whose main aim is to provide the client with relief from the discomfort associated with withdrawal and to prevent (or manage) any severe withdrawal complications. Longer-term changes in behaviour generally require longer-term interventions, such as counselling, or residential rehabilitation interventions. Withdrawal clients who wish to attempt longer-term abstinence should be referred to such interventions, although this should not be a condition of admission to a withdrawal service. Clinical experience and research findings from most stand-alone withdrawal interventions indicate that the majority of clients generally resume their drug use within several weeks or months. To a large degree, this relates to the goals and expectations that many clients bring to treatment. A large proportion of clients enter withdrawal seeking a temporary break from the adverse physical, psychological, or social harms arising from their drug use. However, they may not be prepared (or may not be in a position) to make major lifestyle or behavioural changes. For these clients, there is considerable benefit in the successful and safe completion of their withdrawal; in the provision of relevant harm minimisation information (such as overdose prevention or advice on diet and nutrition); and in linkage to appropriate health, social, and welfare services in order to address drug-related harms.

Maintenance pharmacotherapies

Maintenance pharmacotherapies refer to interventions that involve providing individuals with continuing medication to prevent relapse. In most instances the medication is of the same class as the drug of dependence; for example, heroin and methadone are both opiates. In simple terms it involves replacing the problematic drug with a prescribed, legal drug.

This provides the client with the opportunity to improve significantly their physical health, relationships, and emotional well-being—while also obviating the need to engage in criminal behaviour to support the drug habit and decreasing the likelihood that the client will engage in high-risk harmful behaviour such as injecting heroin with a used syringe. The most prominent example of a maintenance pharmacotherapy is methadone treatment (the next chapter outlines maintenance pharmacotherapy).

Counselling, psychotherapy, and behaviour-change interventions

Behaviour-change treatments are those concerned with providing clients with the capacity to change their patterns of addictive behaviours and the capacity to maintain those changes over time. Successful treatment of drug problems, defined as the cessation of drug use at harmful levels, requires that the client make significant changes to their behaviour. These changes in behaviour may include dealing with emotions differently, acquiring new or altered social skills, managing time effectively, and dealing with interpersonal conflict in an assertive manner (Monti et al. 1989). In addition, the ability to avoid relapse and to manage cravings are central behaviour-change requirements. There are a variety of behaviour-change interventions for alcohol and drug dependence. These include education, individual counselling, relapse prevention, aversion therapy, social-skills training, stress management, therapeutic communities, and cognitive-behaviour therapy programs. Mattick and Jarvis (1993) conducted an extensive review, survey, and meta-analysis of treatment options available for alcohol dependence, and established quality-assurance guidelines for the provision of such treatments. The most widely used behaviour-change intervention is cognitive-behaviour therapy (Hulse et al. 2002).

Cognitive-behaviour therapy

Cognitive-behaviour therapy refers to a broad range of therapeutic interventions. It includes training in specific social skills and adaptive living skills, as well as cognitive interventions. This approach presumes that drug use is preceded by poor skills in coping and living, and that improvements in such skills will lead to a reduction in the need for substance use. Programs tend to cover the following domains of behaviour: interpersonal problem-solving, social-skills, adaptive behaviour, relationship skills, social introductions, assertive behaviour, giving and receiving praise and criticism, structured problem-solving, stress management, relaxation, skills for coping with negative moods, and skills for coping with urges to drink. Monti et al. (1989) have produced what is probably the most comprehensive manual of

cognitive-behaviour therapy for alcohol-dependent individuals. Research has shown that these programs are most cost-effective when conducted in a group-based format on an outpatient basis (Holder et al. 1991; Mattick & Jarvis 1993). Aftercare or, alternatively, continuing follow-up sessions, are regarded as a crucial component of an effective cognitive-behavioural program (Ito & Donovan 1986).

Research into treatment outcomes has highlighted the effectiveness of the cognitive-behavioural approach in relation to alcohol dependence (Sobell & Sobell 1973, 1976; Miller et al. 1980; Miller & Hester 1986a, 1986b, 1986c; Monti et al. 1986, 1989). The underlying principle of the cognitive-behavioural approach is that the acquisition and maintenance of interpersonal and intrapsychic skills enables an individual to cope with life's stressors without resorting to substance use.

Cognitive-behaviour therapy can only be regarded as effective if the skills taught can be applied across a wide variety of situations the client may encounter. These skills also must be able to be maintained over time. Successful cognitive-behaviour therapy needs to teach the client to sustain, over the long term, the changes they have made to their behaviour.

Relapse prevention

Relapse-prevention programs aim to teach clients a set of cognitive and behavioural coping strategies to enhance their capacity to cope with the high-risk situations that precipitate relapse. Relapse prevention aims to reduce the likelihood that a client will recommence using alcohol or drugs after they have succeeded in becoming abstinent for a period of time. It teaches clients a series of skills and interventions that they can use to improve their chances of remaining abstinent. The essential components of a relapse-prevention program are the examination of 'high-risk situations', the development of alternative cognitive and behavioural coping strategies suitable for dealing with these high-risk situations, the understanding and management of cravings and urges, and the understanding and management of the lapse–relapse cycle (Marlatt & Gordon 1985).

Many research studies have shown that relapse-prevention techniques can be effective (Daley & Marlatt 1997). Allsop et al. (1997) compared a relapse-prevention program with a discussion control group and a control group that received no additional treatment. They reported significantly greater increases in self-efficacy in the relapse-prevention subjects. At 6 months post-treatment, relapse-prevention subjects had a longer latency to relapse than those in the control group. Also, the relapse-prevention subjects had a significantly lower probability of relapse than the two control groups. Research has also emphasised that active practising of the skills during therapy is an important aspect of relapse-prevention training, which increases the likelihood of success (Mattick & Jarvis 1993).

One approach to relapse prevention is 'cue exposure'. Cue exposure is a treatment that involves exposing clients to alcohol or drug cues, such as an advertisement for beer, a syringe, or the experience of being in a pub. Previously it had been thought that the best strategy for remaining abstinent was to avoid the drug or the things associated with it. Clients were advised to cut all ties with drug-using friends, not to go to the local pub, and to minimise access to any alcohol- or drug-related objects. However, it is apparent that this can, in some situations, be quite unrealistic. It is also not consistent with other psychological approaches to the treatment of compulsive disorders. We know now, for example, that avoidance behaviour (the avoidance of situations—and people and substances—previously associated with drug use) can contribute to difficulties in coping with a high-risk situation if and when it does arise. Thus, clients who have been treated using avoidance behaviour and who come in contact with drugs or alcohol post-treatment, as they inevitably do, are unlikely to cope well with the situation. Cue exposure aims to redress this problem and attempts to give clients an opportunity to learn coping skills in the presence of alcohol, drugs, or associated cues. For example, during relapse-prevention sessions there are bottles and glasses of alcohol present, or drug paraphernalia such as syringes, spoons, and foil.

A number of authors have called for research on the effectiveness of cue exposure (for example, Mattick & Jarvis 1993; Monti et al. 1989). Dawe et al. (1993) found that there were no significant differences in outcome between opiate users treated with cue exposure and those in other treatments. However, there were problems with the design of this research, including the fact that the effects of the treatments other than cue-exposure treatment were not controlled—for example, in the comparison treatments clients received varying degrees of counselling. A pilot study with alcohol users revealed that, in comparison with clients receiving standard treatment, clients receiving cue-exposure treatment combined with training in coping skills reported a higher percentage of days abstinent and a greater use of coping skills (Monti et al. 1993).

Therapeutic communities

Therapeutic communities differ from other treatment strategies in that treatment is administered to long-term residential clients. The focus of these programs is usually on sustainable changes in behaviour. In addition to psychological and social changes, the main goal is abstinence. That is, global life-style changes are regarded as important. While there are differences between individual programs, most therapeutic communities include such strategies as mutual self-help, an emphasis on work as education and therapy, and the use of peers as role models (De Leon & Zeigenfuss 1986). Programs are highly structured and have defined rules. Many therapeutic

communities are located in outer suburbs or in country areas, where there is less chance of contact between residents and the outside world. Extensive use is made of peer support and peer influence. Residents progress through a series of stages or levels. The role they play in supervising and assisting newer residents increases at each stage.

Australian research has shown that the characteristics common to clients of residential rehabilitation programs include primary heroin users, usually aged between 28 to 32 years, drug use complicated by polydrug use, an average drug-use career of 10 years, and previous treatment attempts (Hall et al. 1995; Kelaher et al. 1995; Ernst & Young 1996). In general, it appears that clients of residential rehabilitation services have complex psychosocial problems, severe drug use issues, and poor physical health status (Blyth & Zavrou 1997; Mattick et al. 1998).

Research into the effectiveness of therapeutic communities, like most research in the field of addictions, has been hampered by poor research design. Some of the difficulties include short follow-up periods, not taking into account the very high rate of drop-out that occurs early in treatment, and uncontrolled studies. In spite of these caveats, there have been a number of United States papers reporting improvements in the well-being of clients, in their psychosocial status, and in relation to their ability to sustain abstinence from drugs. Therapeutic communities have been found to have significant benefits for individual participants as well as for the community as a whole (Toumbourou et al. 1994; Ernst & Young 1996). Gowing et al. (2001), in their review of illicit drug treatment effectiveness, concluded that at least 3 months' treatment is required to achieve change, that high rates of drop-out occur in the first month, and for those who complete treatment, drug use and criminal behaviour are reduced (Gowing et al. 2001).

Length of time in treatment is an important predictor of treatment outcome. Residential rehabilitation aims to instil lasting behavioural change, thus stays of one year may be necessary (De Leon 1995; Mattick et al. 1998; Toumbourou et al. 1998). The greatest challenge, therefore, is to encourage and facilitate longer stays in residential programs.

Outreach and peer support

One of the challenges in providing interventions and treatment to drug users is to reach them in the most effective way. Outreach and peer support services have developed as ways of reaching 'hidden' populations. There is no one clear definition of outreach, and the objectives of the intervention differ depending upon the purpose, scope, and provider. Nonetheless, outreach includes active seeking of the target group, making contact, and engaging the drug user such that they may seek assistance. Contact with clients occurs in the client's own environment—whether this be on the street, at their home, in public spaces, or at cafés (Korf et al. 1999).

Outreach itself has been around for many years. It grew out of youth-based street work. Today, it is being used in mental-health settings, with drug users, and with young people. Mobile treatment teams and assertive community care are variants of outreach. They are designed to meet the immediate needs of the client, with the goal of facilitating engagement with treatment.

Research on the effectiveness of outreach is extremely limited. However, it is clear that outreach can successfully access hidden populations, and can encourage and facilitate entry into treatment (Wechsberg 1993; Gleghorn 1997; Gottheil 1997).

Peer support is seen as a variant of the outreach model. Trained peers are used to access hard-to-reach populations. They aim to bring about behavioural change through peer education, using the status of the peer as influential. Peer interventions are based on the power or potency of being able to influence the group norm—individuals are most likely to change their behaviour if the change is consistent with their peer group's norms. They have been used most widely with HIV prevention programs (Rhodes 1993).

Psychotherapy

Psychoanalysis, psychodynamic psychotherapy, and gestalt therapy, to name a few psychotherapies, have all been applied to individuals seeking behavioural change in relation to problems they are experiencing with drugs (including alcohol). While these treatments are somewhat controversial because of their high intensity and the perceived vagueness of their theoretical underpinnings, they still provide clients with opportunities to explore the ways in which the problems they are experiencing in relation to their drug use are influenced by their childhood, by long-standing behavioural problems they may have, and by their unconscious.

These days, it would be unusual to find an alcohol and drug expert who regards the psychotherapeutic approach as an essential ingredient in the treatment of addiction. However, some will acknowledge that, for certain clients, these approaches are the ones most likely to succeed. For example, those individuals with a psychiatric disorder or a long-standing behavioural disorder are the ones most likely to benefit from long-term psychotherapy.

Other issues

A number of different researchers have estimated that approximately 30 per cent of individuals undergoing treatment are likely to reduce the harm associated with their misuse of alcohol or drugs (for example, Armor et al. 1978). The remainder are likely to continue to experience the negative consequences of this misuse.

Matching the client with the most appropriate treatment is critical. As we have demonstrated in this chapter, there are a variety of treatment models, each of which offers different approaches. The client's choice of treatment goal (abstinence or controlled use) is critically important in choosing a treatment type. The degree to which someone is physiologically dependent will determine whether a withdrawal treatment is required or whether methadone maintenance would be more appropriate. The relative accessibility of treatments, whether they are located in specialist clinics, community health settings, or local venues (such as self-help groups), will largely determine who attends.

It has become apparent that whatever treatment modality is chosen, the critical factor is the therapeutic relationship; that is, the relationship between the individual seeking help and the professional, or peer-support person, with whom they interact. In fact, it is possible that it does not really matter what treatment is provided, as long as the relationship is perceived as genuine and 'empathic', and is seen to provide 'unconditional positive regard' (Rogers 1957).

Najavits and Weiss (1994) found that there are wide-ranging differences between the outcomes provided by different therapists—differences that cannot be accounted for by variables in the backgrounds of clients or by differences in the training and experience of therapists, or even by the theoretical orientations of therapists. They found that it is the interpersonal functioning of the therapist, which includes such factors as empathy, regard, genuineness, and so on, that distinguishes effective from ineffective therapists. Treatment outcome can be predicted by client's perception of the therapist expertise and regard (Ritter et al. 2002).

Joe's story

Joe has a variety of choices. First, it would be sensible for him to determine how he will withdraw from the substances on which he has developed a dependence and whether a residential or non-residential program is most suitable. However, if Joe is interested in methadone treatment, he will not require a withdrawal treatment. His drug use may not be sufficient to warrant methadone treatment. He can visit his GP and be assessed for his suitability for methadone. In addition, he can find out where the local self-help groups are run, and can try out a self-help meeting. If he is interested in controlled drug use, the local alcohol and drug agency will be able to assist him. Cognitive-behavioural interventions and psychotherapy are generally available from alcohol and drug treatment agencies or through private practitioners such as psychologists. Most importantly, Joe needs to feel comfortable, heard, and understood by whomever he seeks assistance from. It is likely that he will try out a few different options, much like buying a car. No one would expect to purchase the first car that they saw. Matching Joe's needs and preferences to the available options is the beginning of recovery.